Physician-Assisted Suicide in an Era of Constrained Medical Resources

Testimony before the Subcommittee on Health and Environment
of the Committee on Commerce of the U.S. House of Representatives

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Summary Points

1. New payment schemes are designed to reward physicians for doing less for patients.

2. End of life care is expensive. There are enormous pressures to control costs.

3. There will be financial incentives to encourage patients to exercise their "right" to assisted suicide if it is legalized in the current medical economic environment.

4. The federal government is encouraging managed care, and so would be indirectly implicated.

5. These fears are realistic. A recent survey has shown that internists who tend to have a practice style that saves money are more likely to be willing to assist a patient in suicide.

6. Safeguards would not work.

7. The fact that such dangers could exist for withholding and withdrawing care is not an argument to extend the range of possible abuses to include assisted suicide.

8. Denying federal funding would not discriminate against the poor. They are afraid of assisted suicide anyway.

My name is Daniel Sulmasy. I am an Assistant Professor in the Division of General Internal Medicine and Director of the Center for Clinical Bioethics at Georgetown University. I hold an M.D. degree as well as a Ph.D. degree in philosophical ethics. I continue an active medical practice at Georgetown in addition to my teaching and research in bioethics.

I am here today to alert the members of this Sub-Committee and the general public to the clear and present dangers posed by the legalization of physician assisted suicide in the current atmosphere of intense pressure upon all health care professionals to control costs and of the new payment schemes introduced by managed care organizations in which health care professionals stand to make more money if they provide less care for patients. The simple arithmetic is brutally clear. Persons who become ill with diseases like cancer, AIDS, and Lou Gehrig's Disease are expensive to care for. The highest portion of Medicare payments are made for patients in the last 12 months of life. These patients represent a substantial portion of what managed care organizations now call the "medical loss ratio" -- the amount of potential profit lost to actual patient care. They also generate a substantial number of the tests, treatments, and specialist referrals that now count *against* the incomes of physicians. In addition, there are emerging data to suggest that managed care organizations have an incentive to cut back on allotments for hospice care. Thus, at both the macro and the micro levels of the organization, the incentives are all aligned to encourage physician assisted suicide. Income is maximized by persuading sick, terminally patients, who have paid their premiums, that the very best course of action for them would be to avoid needless suffering by exercising their right to a quick final exit through assisted death.

Regardless of whether one believes that physician assisted suicide is inherently immoral, or

threatens fundamental premises of the rule of law and the protection of citizens by the State, it seems to me, as I hope it will seem to you, unwise to provide federal health care dollars to underwrite this practice.

It is important to note that one of the ways in which the federal government has elected to control health care costs is by the enrollment of Medicare and Medicaid recipients in managed care organizations. This would mean that the federal government would be implicated in the suicides of its vulnerable, terminally ill citizens, by indirectly encouraging these practices.

Those who think the scenario I am depicting is unrealistic perhaps do not understand how managed care organizations have fundamentally changed the incentives for physicians, nor how much pressure is now brought to bear upon physicians to control costs. For instance, my fiscal performance in caring for patients cheaply is constantly profiled by managed care organizations. I have daily arguments on the phone to get patients into the hospital. I am told that I must send my patients to inadequate care settings cynically labeled, "hospice". As director of our ethics consult service, I have even received a telephone call from an insurance reviewer in Arizona asking that our ethics service explore why a terminally ill client of theirs had been connected to a ventilator. The pressures on physicians to control costs are relentless. We physicians are not monsters, but we *are* human. We tend to do what is easiest to do, what is legally safe to do, and what winds up being in our own best interests. Physician assisted suicide may soon meet all three criteria.

Further, my research group has recently conducted a survey in which we have demonstrated that internists who tend consistently to choose the cheaper course of action in a series of hypothetical case scenarios are 6.4 times as likely as their resource liberal colleagues to be willing to assist in a patient's suicide. These data do not *prove* a cause and effect link between

cost control and physician assisted suicide, but the existence of such a link warrants some pause and examination before legalizing physician assisted suicide and paying for it with federal dollars.

Some might suggest that safeguards can be built into the system to prevent these sorts of actions, but I believe this is naive. If Jack Kevorkian can blatantly and defiantly violate the law and escape conviction, who is willing to believe that the innumerable quiet, private conversations that would take place between physicians and their patients under legalization could be regulated? The profound Aesculapian power of the physician to persuade vulnerable, dying patients through subtle shades of meaning could *not* be effectively policed.

Others might argue that there is already a danger of these economic forces influencing the decisions now made to withhold and withdraw life-sustaining treatments. I agree with the fact that there is such a danger, and this also troubles me. But I fail to see how this can be construed as a reason to extend the range of possible abuses to include the most dramatic and irreversible -- assisted suicide.

Finally, there are also persons who argue that it would be unjust to deny payment for suicide for the poor when this practice would be available to the wealthy. However, this argument is specious from a practical perspective. First, many managed care organizations that serve those who are better off, in an effort to protect themselves from the charge of such crass conflict of interest, have already pledged that they will *not* provide coverage for assisted suicide for their enrollees. Second, numerous surveys have demonstrated that minorities, who are disproportionately represented among those receiving Medicaid, are strongly opposed to the legalization of physician assisted suicide. I suspect this is because they recognize in a more direct way the dangers I have outlined in this testimony.

Thus, in light of the potentially combustible consequences of adding physician assisted suicide to a highly cost-constrained medical environment, I urge the members of this Sub-Committee to do whatever they can to protect vulnerable patients from the considerable dangers. Thank you.

Appendices

1. “Managed Care and Managed Death” by Daniel P. Sulmasy, MD, PhD [article]
2. “Use of Medical Resources and Physician Willingness to Participate in Assisted Suicide” by Benjamin Linas, Karen Gold, Kevin Schulman, and Daniel Sulmasy [abstract]